		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0027052

Facility Name: LAKE PARK CENTER

Address: 919 WASHINGTON PARK (Number) WAUKEGAN (City) 60085 (Zip Code)

County: LAKE

Telephone Number: (847) 623-9100 **Fax #** (847) 623-9179

IDPA ID Number: 36-3109638

Date of Initial License for Current Owners: 02/01/81

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) MORRIS ESFORMES
(Title) GENERAL PARTNER

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	210	Skilled (SNF)	210	76,650	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	210	TOTALS	210	76,650	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	69,251	61	5,263	74,575	11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	69,251	61	5,263	74,575	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.29%

D. How many bed-hold days during this year were paid by Public Aid?
818 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started _____

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/81 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	248,880	13,244	8,590	270,714		270,714	0	270,714			1
2	Food Purchase		185,196		185,196		185,196	(683)	184,513			2
3	Housekeeping	178,513	28,150	0	206,663		206,663	0	206,663			3
4	Laundry	89,974	17,454	1,434	108,862		108,862	0	108,862			4
5	Heat and Other Utilities			175,210	175,210		175,210	542	175,752			5
6	Maintenance	103,026	9,628	28,905	141,559		141,559	7,293	148,852			6
7	Other (specify):*			15,906	15,906		15,906	158	16,064			7
8	TOTAL General Services	620,393	253,672	230,045	1,104,110	0	1,104,110	7,310	1,111,420			8
	B. Health Care and Programs											
9	Medical Director	0		4,960	4,960		4,960	0	4,960			9
10	Nursing and Medical Records	1,949,596	171,559	31,562	2,152,717		2,152,717	0	2,152,717			10
10a	Therapy	77,821		7,773	85,594		85,594	0	85,594			10a
11	Activities	103,874	2,529	4,124	110,527		110,527	0	110,527			11
12	Social Services	0		3,965	3,965		3,965	0	3,965			12
13	Nurse Aide Training			13,200	13,200		13,200	0	13,200			13
14	Program Transportation			541	541		541	0	541			14
15	Other (specify):*				0		0	0	0			15
16	TOTAL Health Care and Programs	2,131,291	174,088	66,125	2,371,504	0	2,371,504	0	2,371,504			16
	C. General Administration											
17	Administrative	96,541		704,300	800,841		800,841	(681,922)	118,919			17
18	Directors Fees			0	0		0	0	0			18
19	Professional Services			27,486	27,486		27,486	13,798	41,284			19
20	Dues, Fees, Subscriptions & Promotions			26,935	26,935		26,935	(6,075)	20,860			20
21	Clerical & General Office Expenses	65,426	13,446	177,232	256,104		256,104	(98,576)	157,528			21
22	Employee Benefits & Payroll Taxes			451,330	451,330		451,330	0	451,330			22
23	Inservice Training & Education			2,514	2,514		2,514	133	2,647			23
24	Travel and Seminar			1,302	1,302		1,302	0	1,302			24
25	Other Admin. Staff Transportation			67,910	67,910		67,910	928	68,838			25
26	Insurance-Prop.Liab.Malpractice			126,673	126,673		126,673	4,789	131,462			26
27	Other (specify):*			0	0		0	12,829	12,829			27
28	TOTAL General Administration	161,967	13,446	1,585,682	1,761,095	0	1,761,095	(754,096)	1,006,999			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,913,651	441,206	1,881,852	5,236,709	0	5,236,709	(746,786)	4,489,923			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number LAKE PARK CENTER #0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			67,734	67,734		67,734	(14,987)	52,747			30
31	Amortization of Pre-Op. & Org.				0		0	0	0			31
32	Interest			1,930	1,930		1,930	2,582	4,512			32
33	Real Estate Taxes			96,547	96,547		96,547	1,226	97,773			33
34	Rent-Facility & Grounds			506,754	506,754		506,754	0	506,754			34
35	Rent-Equipment & Vehicles			33,782	33,782		33,782	5,931	39,713			35
36	Other (specify):* Office Rent			15,750	15,750		15,750	(15,750)	0			36
37	TOTAL Ownership			722,497	722,497	0	722,497	(20,998)	701,499			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation				0		0	0	0			38
39	Ancillary Service Centers				0		0	0	0			39
40	Barber and Beauty Shops				0		0	0	0			40
41	Coffee and Gift Shops				0		0	0	0			41
42	Provider Participation Fee			114,975	114,975		114,975	0	114,975			42
43	Other (specify):*				0		0	0	0			43
44	TOTAL Special Cost Centers	0	0	114,975	114,975	0	114,975	0	114,975			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,913,651	441,206	2,719,324	6,074,181	0	6,074,181	(767,784)	5,306,397			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(17,320)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(683)	2		13
14	Non-Care Related Interest	0	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(400)	20		17
18	Fines and Penalties	0	21		18
19	Entertainment	0	20		19
20	Contributions	(4,777)	20		20
21	Owner or Key-Man Insurance	0	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	0	27		24
25	Fund Raising, Advertising and Promotional	(694)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,252)	20		28
29	Other-Attach Schedule SEE PAGE 5A	(13,811)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (38,937)		$ 0	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(728,847)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (728,847)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (767,784)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

LAKE PARK CENTER

ID# 0027052

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 2739	6	1
2	STAFF DEVELOPMENT	(16,550)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(13,811)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number LAKE PARK CENTER # 0027052 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(683)	0	0	0	0	0	0	0	0	0	0	(683)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	542	0	0	0	0	0	0	0	0	542	5
6	Maintenance	2,739	3,041	1,513	0	0	0	0	0	0	0	0	7,293	6
7	Other (specify):*	0	158	0	0	0	0	0	0	0	0	0	158	7
8	**TOTAL General Services**	2,056	3,199	2,055	0	0	0	0	0	0	0	0	7,310	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	(681,922)	0	0	0	0	0	0	0	(681,922)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,011	128	659	0	0	0	0	0	0	0	13,798	19
20	Fees, Subscriptions & Promotions	(7,123)	1,048	0	0	0	0	0	0	0	0	0	(6,075)	20
21	Clerical & General Office Expenses	(16,550)	(92,774)	539	10,209	0	0	0	0	0	0	0	(98,576)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	133	0	0	0	0	0	0	0	0	0	133	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	231	0	697	0	0	0	0	0	0	0	928	25
26	Insurance-Prop.Liab.Malpractice	0	3,457	139	1,193	0	0	0	0	0	0	0	4,789	26
27	Other (specify):*	0	8,547	0	4,282	0	0	0	0	0	0	0	12,829	27
28	**TOTAL General Administration**	(23,673)	(66,347)	806	(664,882)	0	0	0	0	0	0	0	(754,096)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(21,617)	(63,148)	2,861	(664,882)	0	0	0	0	0	0	0	(746,786)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number LAKE PARK CENTER **#** 0027052 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(17,320)	585	1,290	458	0	0	0	0	0	0	0	(14,987)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	639	1,943	0	0	0	0	0	0	0	0	2,582	32
33	Real Estate Taxes	0	0	1,226	0	0	0	0	0	0	0	0	1,226	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	3,927	0	2,004	0	0	0	0	0	0	0	5,931	35
36	Other (specify):*	0	0	(15,750)	0	0	0	0	0	0	0	0	(15,750)	36
37	**TOTAL Ownership**	(17,320)	5,151	(11,291)	2,462	0	0	0	0	0	0	0	(20,998)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(38,937)	(57,997)	(8,430)	(662,420)	0	0	0	0	0	0	0	(767,784)	45

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SCHEDULE ATTACHED		LIST ATTACHED		EKS MANAGEMENT	LINCOLNWOOD	MANAGEMENT
				EMI ENTERPRISES	LINCOLNWOOD	CONSULTANT
				IME REALTY CORP	LINCOLNWOOD	HOME OFFICE

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21	OUTSIDE CATERING	$ 143,640			$	$ (143,640)	1
2	V		6	PAINTING/ DECORATING		EKS MANAGEMENT		3,041	3,041	2
3	V		7	SCAVENGER				158	158	3
4	V		19	PROFESSIONAL FEES				13,011	13,011	4
5	V		20	WANT ADS/BACKGR CKS				1,048	1,048	5
6	V		21	TOTAL OFFICE				50,866	50,866	6
7	V		23	SEMINAR				133	133	7
8	V		25	TRANSPORTATION				231	231	8
9	V		26	INSURANCE				3,457	3,457	9
10	V		27	EMPLOYEE BENEFITS				8,547	8,547	10
11	V		30	DEPRECIATION (SL)				585	585	11
12	V		32	INTEREST-INSURANCE FIN.				639	639	12
13	V		35	EQUIPMENT RENTAL				3,927	3,927	13
14	Total				$ 143,640			$ 85,643	$ * (57,997)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	36	OFFICE RENT	$ 15,750	IME REALTY CORP.		$	$ (15,750)	15
16	V	5	UITLITIES				542	542	16
17	V	6	REPAIR/MAINTENANCE				1,513	1,513	17
18	V	19	PROFESSIONAL FEES				128	128	18
19	V	21	OFFICE EXPENSE				539	539	19
20	V	26	INSURANCE				139	139	20
21	V	30	DEPRECIATION (SL)				1,290	1,290	21
22	V	32	INTEREST				1,943	1,943	22
23	V	33	REAL ESTATE TAX				1,226	1,226	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 15,750			$ 7,320	$ * (8,430)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 704,300	EMI ENTERPRISES, INC.		$	$ (704,300)	15
16	V	17	OFFICERS SALARY				22,378	22,378	16
17	V	19	ACCOUNTING FEES				659	659	17
18	V	21	TOTAL OFFICE				10,209	10,209	18
19	V	25	TRANSPORTATION				697	697	19
20	V	26	INSURANCE				1,193	1,193	20
21	V	27	EMPLOYEE BENEFITS				4,282	4,282	21
22	V	30	DEPRECIATION				458	458	22
23	V	35	AUTO LEASE				2,004	2,004	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 704,300			$ 41,880	$ * (662,420)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MORRIS ESFORMES	GEN. PARTNER	ADMINISTRAT.	0.48	SEE ATTACHED	4		SALARY	$ 22,378	17-8	1
2					SCHEDULE						2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,378		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EKS MANAGEMENT
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-5795
Fax Number: (847) 674-5794

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	PAINTING/ DECORATING	PATIENT DAYS	616,513	11	$ 25,141	$	74,575	$ 3,041	1
2	7	SCAVENGER	PATIENT DAYS	616,513	11	1,310		74,575	158	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	616,513	11	107,563	91,129	74,575	13,011	3
4	20	WANT ADS/BACKGR CKS	PATIENT DAYS	616,513	11	8,660		74,575	1,048	4
5	21	TOTAL OFFICE	PATIENT DAYS	616,513	11	420,511	316,407	74,575	50,866	5
6	23	SEMINAR	PATIENT DAYS	616,513	11	1,100		74,575	133	6
7	25	TRANSPORTATION	PATIENT DAYS	616,513	11	1,912		74,575	231	7
8	26	INSURANCE	PATIENT DAYS	616,513	11	28,579		74,575	3,457	8
9	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	70,657		74,575	8,547	9
10	30	DEPRECIATION (SL)	PATIENT DAYS	616,513	11	4,837		74,575	585	10
11	32	INTEREST-INSURANCE FIN.	PATIENT DAYS	616,513	11	5,286		74,575	639	11
12	35	EQUIPMENT RENTAL	PATIENT DAYS	616,513	11	32,463		74,575	3,927	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 708,019	$ 407,536		$ 85,643	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: IME REALTY CORP
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1962

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	INCOME	203,249	11	$ 6,990	$	15,750	$ 542	1
2	6	REPAIR.MAINTENANCE	INCOME	203,249	11	19,525		15,750	1,513	2
3	19	PROFESSIONAL FEES	INCOME	203,249	11	1,650		15,750	128	3
4	21	OFFICE EXPENSE	INCOME	203,249	11	6,958		15,750	539	4
5	26	INSURANCE	INCOME	203,249	11	1,798		15,750	139	5
6	30	DEPRECIATION (SL)	INCOME	203,249	11	16,647		15,750	1,290	6
7	32	INTEREST	INCOME	203,249	11	25,074		15,750	1,943	7
8	33	REAL ESTATE TAX	INCOME	203,249	11	15,815		15,750	1,226	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 94,457	$		$ 7,320	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: EMI ENTERPRISES, INC.
Street Address: 3737 W. ARTHUR AVE.
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (847) 674-1946
Fax Number: (847) 674-1963

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICERS SALARY	PATIENT DAYS	616,513	11	$ 185,000	$ 185,000	74,575	$ 22,378	1
2	19	ACCOUNTING FEES	PATIENT DAYS	616,513	11	5,451		74,575	659	2
3	21	TOTAL OFFICE	PATIENT DAYS	616,513	11	84,399	60,672	74,575	10,209	3
4	25	TRANSPORTATION	PATIENT DAYS	616,513	11	5,763		74,575	697	4
5	26	INSURANCE	PATIENT DAYS	616,513	11	9,863		74,575	1,193	5
6	27	EMPLOYEE BENEFITS	PATIENT DAYS	616,513	11	35,399		74,575	4,282	6
7	30	DEPRECIATION	PATIENT DAYS	616,513	11	3,788		74,575	458	7
8	35	AUTO LEASE	PATIENT DAYS	616,513	11	16,569		74,575	2,004	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 346,232	$ 245,672		$ 41,880	25

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7	OXFORD INSURANCE		X	INSURANCE FINANCING							1,930	7
8	MGMT CO ALLOCATION										2,582	8
9	TOTAL Facility Related						$ 0	$ 0			$ 4,512	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 0	$ 0			$ 0	14
15	TOTALS (line 9+line14)						$ 0	$ 0			$ 4,512	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 88,164	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 91,441	2
3. Under or (over) accrual (line 2 minus line 1).		$ 3,277	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 93,270	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 96,547	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	82,838	8
	1997	87,519	9
	1998	88,969	10
	1999	88,164	11
	2000	91,441	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 102% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2000 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME LAKE PARK CENTER COUNTY LAKE

FACILITY IDPH LICENSE NUMBER 0027052

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-29-400-032	Nursing Home	$ 91,441.40	$ 91,441.40
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 91,441.40	$ 91,441.40

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 60,175 B. General Construction Type: Exterior BRICK Frame CONCRETE Number of Stories

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$ 0	3

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8	IME ALLOCATION					1,057		1,057			8
	Improvement Type**										
9	PAINTING			1986	15,680	139	15	131	(8)	14,431	9
10	ASHALT PAVING			1987	8,180	260	15	545	285	7,720	10
11	AVAC UNITS			1988	45,000	1,429	20	2,250	821	30,563	11
12	ROOFING			1989	56,815	1,804	31.5	1,804		21,949	12
13	CUBICLE CURTAIN & TILE			1991	20,473	650	31.5	650		6,798	13
14	PARKING LOTS			1993	19,440	1,296	15	1,296		10,700	14
15	CUBICLE CURTAINS			1993	1,796	46	31.5	57	11	466	15
16	NURSE STATION			1993	7,800	200	31.5	248	48	2,022	16
17	ELEVATOR			1994	22,300	572	39	572		4,266	17
18	CUBICLE CURTAINS			1994	843	22	39	22		171	18
19	PARKING LOTS LIGHTS			1995	8,677	578	15	578		3,757	19
20	REPAIR STONE FASCIA			1995	9,750	250	39	250		1,615	20
21	INSULATE SUPPLY/DUCT WORK			1995	7,190	185	39	185		1,140	21
22	TILE			1996	20,387	522	39	522		2,764	22
23	WEATHER-ROOFTOP			1997	6,408	164	39	164		663	23
24	METAL DOORS & AIR CONDITION			1998	11,993	308	39	308		1,193	24
25	TWO SHOWERS			1998	2,720	70	39	70		265	25
26	NEW ROOFING SYSTEM ABOVE KITCHEN			1998	9,800	251	39	251		868	26
27	CABINNERY-ADM., BOOKKEPING, DON			1998	33,000	846	39	846		2,785	27
28	WATER HEATER			1998	4,639	119	39	119		372	28
29	INSTALLED SMOKE AND DUST DETECTORS			1999	4,572	117	39	117		298	29
30	FURNISH AND INSTALL FIRE DAMPERS			1999	25,971	666	39	666		1,582	30
31	FOUR DOORS GIBS, RESTRICTORS, ACCESS DOOR FIRE			1999	18,547	476	39	476		972	31
32	WATER HEATER, HEAT EXCHANGER, HOT WATER TANK			1999	8,640	222	39	222		472	32
33	FIRE DAMPERS			2000	8,070	293	20	293		452	33
34	FENCE			2000	6,810	454	15	454		530	34
35	CUBICLE CURTAINS			2001	14,018	2,804	20	701	(2,103)	701	35
36	ROOF MAINTENANCE & FLASHING REPAIR			2001	6,950	179	27.5	253	74	253	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINT ALL INTERIOR WALLS	2001	$ 2,800	$ 64	27.5	$ 102	$ 38	$ 102	37
38	IN GROUP PISTON SEALS FOR ELEVATOR	2001	44,895	8,979	20	2,245	(6,734)	2,245	38
39	DRYWALL & SEAL WALLS ROOF	2001	28,812	306	27.5	1,048	742	1,048	39
40	ROOF TOP UNITS	2001	12,900	20	27.5	469	449	469	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 495,876	$ 25,348		$ 18,971	$ (6,377)	$ 123,632	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 495,876	$ 25,348		$ 18,971	$ (6,377)	$ 123,632	1
2									2
3									3
4									4
5									5
6									6
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32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 495,876	$ 25,348		$ 18,971	$ (6,377)	$ 123,632	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 160,177	$ 8,936	$ 15,246	$ 6,310	5-10 YR	$ 112,356	71
72	Current Year Purchases	172,533	34,507	17,254	(17,253)	5-10 YR	17,254	72
73	Fully Depreciated Assets	163,928	0	0	0		163,928	73
74	IME,EKS,EMI ALLOCATION		1,276	1,276	0			74
75	TOTALS	$ 496,638	$ 44,719	$ 33,776	$ (10,943)		$ 293,538	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$ 0		$	76
77							0			77
78							0			78
79							0			79
80	TOTALS			$ 0	$ 0	$ 0	$ 0		$ 0	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 992,514	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 70,067	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,747	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (17,320)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 417,170	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: WAUKEGAN HEALTH CARE INC.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1967	210		$ 506,754			3
4	Additions							4
5								5
6								6
7	TOTAL		210		$ 506,754 **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 02/01/86
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2002	$ 506,754
13.	12/31/2003	$ 506,754
14.	12/31/2004	$ 506,754

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 10,547 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	NURSE, ACTIVITY	1998 VAN	$ 1,000.00	$ 1,000	17
18	ADM	1999 TOYOTA SIENNA	586.00	7,057	18
19	FACILITY	2001 CHEVY VAN	699.00	9,236	19
20	MAINTENANCE	2001 FORD TRUCK	594.00	5,942	20
21	TOTAL		$ 2,879.00	$ 23,235	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 12,150	$	$ 12,150
2	Books and Supplies		1,050		1,050
3	Classroom Wages (a)				0
4	Clinical Wages (b)				0
5	In-House Trainer Wages (c)				0
6	Transportation				0
7	Contractual Payments				0
8	Nurse Aide Competency Tests				0
9	TOTALS	$ 0	$ 13,200	$ 0	$ 13,200
10	SUM OF line 9, col. 1 and 2 (e)	$ 13,200			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	21
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	21

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits					N/A		6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number LAKE PARK CENTER **#** 0027052 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2001 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (231,195)	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,358,401		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	141,771		6
7	Other Prepaid Expenses	4,309		7
8	Accounts Receivable (owners or related parties)	401,788		8
9	Other(specify): Real Estate Escrow Deposit	42,176		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,717,250	$ 0	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	495,876		15
16	Equipment, at Historical Cost	496,638		16
17	Accumulated Depreciation (book methods)	(458,524)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): OPTION DEPOSITS	100,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 633,990	$ 0	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,351,240	$ 0	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 218,460	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	94,400		30
31	Accrued Taxes Payable (excluding real estate taxes)	39,362		31
32	Accrued Real Estate Taxes(Sch.IX-B)	93,270		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 445,492	$ 0	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 0	$ 0	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 445,492	$ 0	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,905,748	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,351,240	$ 0	48

***(See instructions.)**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,891,679	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,891,679	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,087,069	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(1,073,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 14,069	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 0	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,905,748	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 7,178,772	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 7,178,772	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 0	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 0	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	374	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 374	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 0	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,179,146	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,104,110	31
32	Health Care	2,371,504	32
33	General Administration	1,761,095	33
	B. Capital Expense		
34	Ownership	722,497	34
	C. Ancillary Expense		
35	Special Cost Centers	0	35
36	Provider Participation Fee	114,975	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,074,181	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,104,965	41
42	**Income Taxes**	(17,896)	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,087,069	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** NO **If not, please attach a reconciliation.** **TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 72,812	$ 35.01	1
2	Assistant Director of Nursing					2
3	Registered Nurses	44,334	46,605	772,749	16.58	3
4	Licensed Practical Nurses	5,411	6,117	126,613	20.70	4
5	Nurse Aides & Orderlies	89,456	95,694	946,668	9.89	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	6,220	6,576	77,821	11.83	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	10,554	11,216	103,874	9.26	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	23,718	25,461	248,880	9.77	15
16	Dishwashers					16
17	Maintenance Workers	7,549	7,932	103,026	12.99	17
18	Housekeepers	22,291	22,910	178,513	7.79	18
19	Laundry	9,689	10,310	89,974	8.73	19
20	Administrator	2,092	2,092	96,541	46.15	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,530	7,772	65,426	8.42	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Quality Assurance	2,134	2,134	30,754	14.41	33
34	TOTAL (lines 1 - 33)	233,058	246,899	$ 2,913,651 *	$ 11.80	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 8,160	1-3	35
36	Medical Director	O	4,960	9-3	36
37	Medical Records Consultant	N	4,378	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	8,280	10-3	39
40	Physical Therapy Consultant	L	2,194	10a-3	40
41	Occupational Therapy Consultant	Y	5,579	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	F	4,124	11-3	44
45	Social Service Consultant	E	3,965	12-3	45
46	Other(specify)	E			46
47	PSYCHIATRIC	S	6,625	10-3	47
48	DENTAL		3,575	10-3	48
49	TOTAL (lines 35 - 48)		$ 51,840		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides		N/A		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
BRIAN LIVINGS	ADMIN	0	$ 96,541
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 96,541

B. Administrative - Other

Description		Amount
EMI	MANAGEMENT FEES	$ 704,300
TOTAL (agree to Schedule V, line 17, col. 3)		$ 704,300
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
ALPHA DATA	DATA PROCESSING	$ 3,992
MIDAMERICA PROGRAM	DATA PROCESSING	1,320
MAXX SOURCE	DATA PROCESSING	1,500
NCS DATA PROCESSING	DATA PROCESSING	9,032
KRUPNICK BOKOR	ACCOUNTING	11,100
PERSONNEL PLANNERS	U.C. CONSULTANT	542
		27,486
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 27,486

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 64,782
Unemployment Compensation Insurance	17,992
FICA Taxes	221,779
Employee Health Insurance	117,492
Employee Meals	0
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	0
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	29,285
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 451,330

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	11,813
Health Care Worker Background Check	2,730
(Indicate # of checks performed 227)	
MARKETING/ADV/PROMO	1,946
TRUST FEES/LICENSES & PERMITS	1,448
CONTRIBUTIONS	4,777
DUES & SUBSCRIPTIONS	4,895
MGMT CO ALLOCATION	1,048
TRUST FEES/CONTRIBUTIONS	(5,851)
Less: Public Relations Expense	(0)
Non-allowable advertising	(694)
Yellow page advertising	(1,252)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 20,860

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	1,302
Seminar Expense	
	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,302

**See instructions.

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	PAINT/DECORATING	1998	$ 8,573	3 YR	$ 1,429	$ 2,858	$ 2,858	$ 1,428	$	$	$	$	$
2	PAINT/DECORATING	1999	3,934	3 YR		656	1,311	1,311	656				
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 12,507		$ 1,429	$ 3,514	$ 4,169	$ 2,739	$ 656	$	$	$	$

Facility Name & ID Number LAKE PARK CENTER # 0027052 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $4489**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **378** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **114,975**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **NO**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	8,160	
	REPAIRS & MAINTENANCE		430	
			0	8,590
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		1,434	
			0	1,434
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		62,391	
	ELECTRICITY		49,915	
	WATER		62,904	
	CABLE TV - LOBBY		0	
			0	175,210
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		562	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		7,767	
	ELEVATOR MAINTENANCE & REPAIR		13,641	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		3,648	
	FIRE SERVICE		3,287	
			0	
			0	
			0	28,905
7	**OTHER**			
	SCAVENGER		11,781	
	SECURITY SERVICE		4,125	15,906
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	4,960	4,960

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		4,113	
	PURCHASED SERVICES		4,591	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,378	
	PHARMACY CONSULTANT	XVIII B 39-2	8,280	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	6,625	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL		3,575	
			0	31,562
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	2,194	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	5,579	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	7,773
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	4,124	
			0	4,124
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	3,965	
	SOCIAL WORKER	XVIII B 45-2	0	
			0	3,965
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	13,200	13,200

Facility Name & ID Number LAKE PARK CENTER **#0027052** **Report Period Beginning: 01/01/2001** **Ending: 12/31/2001**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		541	541
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	704,300	704,300
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	15,844	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	11,642	
			0	27,486
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	694	
	EMPLOYEE WANT ADS	XIX F	11,813	
	CONTRIBUTIONS	VI 20 XIX F	2,000	
	DUES & SUBSCRIPTIONS	XIX F	4,895	
	LICENSES & PERMITS	XIX F	374	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	1,252	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	400	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	2,777	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,730	26,935
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES		0	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		143,640	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,042	
	MESSENGER SERVICE		0	
	STAFF DEVELOPMENT		16,550	177,232

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	221,779	
	UNEMPLOYMENT COMPENSATION	XIX D	17,992	
	WORKERS COMPENSATION INSURANC	XIX D	64,782	
	HOSPITALIZATION INSURANCE	XIX D	117,492	
	EMPLOYEE BENEFITS - OTHER	XIX D	0	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	29,285	
	CHICAGO HEAD TAX	XIX D	0	451,330
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		2,514	2,514
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	1,302	
			0	
			0	1,302
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		67,910	67,910
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		126,673	126,673
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,881,852

LAKE PARK CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2001

TOTAL FOOD PURCHASE	185,196
LESS SALES TAX	(683)
NET FOOD	185879
TOTAL PATIENT CENSUS	74,575
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	223725
ADD # EMPLOYEE MEALS/DAY	0
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	0

PATIENT MEALS	223725
ADD EMPLOYEE MEALS	0
TOTAL MEALS/YEAR	223725
NET FOOD	185879
DIVIDE TOTAL MEALS/YEAR	223725
COST PER MEAL	0.83
TIME EMPLOYEE MEALS	0
EMPLOYEE MEAL RECLASSIFICATION	0